

Participant ID:					

 Date:

D	D	-	M	M	-	Y	Y	Y	Y
---	---	---	---	---	---	---	---	---	---

Month 2 Participant Reported Symptoms

Please read each statement then tick one response

Over the last week, how much have the following symptoms affected you?

Symptom	Not at all	A little	Somewhat	Quite a lot	A great deal
Feeling tired					
Being out of breath when I walk					
Being out of breath when I am at rest					
Feeling dizzy or lightheaded					
Having a sore tongue					
Having restless legs during sleep					
Having cramps in my legs at night					